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Letter to Editor

Facilitating timely cancer care in a surgical oncology subspecialty unit during the pandemic and recovery phase of the COVID era

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To the Editor,

Current evidence suggest COVID-19 consequences are more severe in cancer patients who have a weakened immune system.¹ Cancer care delivery should remain robust in view of potential disease progression if diagnosis and treatment are delayed.² We describe herein key strategies in the Department of Sarcoma, Peritoneal and Rare Tumours (SPRinT) at the National Cancer Centre Singapore (NCCS) to provide effective care for patients with complex oncological conditions.

Table 1

Comparison of surgical cases treated by our surgical oncology unit in 2019 and 2020.

	Time period 7 Feb to 15 May 2020	7 Feb to 15 May 2019
Number of cases handled by 1 surgical oncologist	89 (91.8%)	75 (80.6%)
Number of cases handled by ≥2 surgical oncologists operating together	8 (8.2%)	18 (19.4%)
Number of benign cases (%)	7 (7.2%)	21 (22.6%)
Acute surgical emergency (%)	2 (2.1%)	
Symptomatic (%)	2 (2.1%)	
Underlying malignancy and surgery required to continue adjuvant therapy (%)	3 (3.0%)	
Number of suspicious/malignant cases (%)	90 (92.8%)	72 (77.4%)
Number of operations (%)		
Tables 1 and 2 ^a	13 (13.4%)	22 (23.7%)
Tables 3 and 4 ^a	36 (37.1%)	41 (44.1%)
Tables 5 and 6 ^a	35 (36.1%)	18 (19.3%)
Table 7 ^a	13 (13.4%)	12 (12.9%)
Median duration of operation (min)		
Tables 1 and 2 ^a	70.0	25.0
Tables 3 and 4 ^a	132.5	90.0
Tables 5 and 6 ^a	195.0	192.5
Table 7 ^a	460.0	372.5
New outpatient caseload	91	122
Follow-up outpatient caseload	580	813
Maximum duration of waiting time for new referral to be seen in clinic (days)	3.7 (5–6)	16.3 (12–13)

^a Table codes are described in detail in [Supplementary Table S1](#).

1.3. Efficacious manpower deployment to maintain efficiency

Under institutional guidelines, malignant cases, suspicious or high-risk cases of malignancy, and surgical emergencies were allowed to proceed while other surgeries were postponed. Furthermore, during this pandemic, surgical emergencies were diverted to the acute surgical team, allowing efficient deployment of manpower within the SPRinT team to maintain a high patient load.

2. Our Results

We demonstrate herein positive results showing no compromise in the timing of cancer care delivery and patient outcomes following implementation of our surgical unit's key strategies (Table 1). Fewer diagnostic and benign cases (table codes 1–4, Supplementary Table S1) while more complex surgeries were performed (table codes 5–7, Supplementary Table S1). Although median operating duration was longer in 2020, partially contributed by the turnover time and recovery of patients with the anesthetic team, surgical caseload was similar in both years. Furthermore, complication rates (Clavien-Dindo grade 3 and above) between 2020 and 2019 were similar at 2.1% and 2.2%, respectively.

With a deferment in non-urgent cases, an overall decrease in patient numbers were seen in clinic (Table 1). Similarly, follow-up cases was fewer in 2020 at 580 compared to 813 in 2019. Notably, mean maximum duration of waiting time for a new referral to be seen in clinic was shorter in 2020 compared to 2019 at 3.7 (range: 5–6) and 16.3 (range: 12–13) days, respectively.

Despite the challenges presented during the COVID-19 pandemic, our surgical oncology subspecialty unit provided timely oncological surgery and care without compromising patient outcomes. In countries recovering from the pandemic and ramping up cancer care, these strategies will provide a useful framework and are worth considering.

Declaration of competing interest

None.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.asjsur.2020.07.005>.

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